## CONFIDENTIAL CASE REPORT

Last Name:	First Name	e:Pho	ne Number: ()
Address: Street Number: _	Street: _		
Locality:		:	Zip Code:
Date of Birth:	//Age	e: Census:	
Symptoms:	Race Choose all that apply.  White Black Amer. Ind./Alaskan Asian Native Hawaiian or/ Other Pacific Islander Other Unknown  Diagnosis: tory data, treatment, etc):		Sex    Male   Female   Unknown      Hospitalized   Yes   No     Admission Date   / / (MM/DD/YYYY)     Name of Hospital     Chart #
Name of Lab:			
Reporting Individual:	vidual: Phone Number: ()		
Date of Report:/	<u>/</u>		
DOH 389 (7/03)			